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ABSTRACT

This article presents findings from recent research demonstrating a significant relationship between parental introjects, or "voices," and self-destructive behavior. The "voice" is defined as a systematized, integrated pattern of negative thoughts accompanied by angry affect, that is the basis of an individual's maladaptive behavior. The development of these negative thought processes often is attributable to childhood trauma due to inadequate, immature, or hostile parenting of the individual in question. This theoretical construct of "voice" led to the development of the Firestone Voice Scale for Self-Destructive Behavior. Results of administering the scale to 507 subjects in psychotherapy showed that the instrument distinguished between individuals with a past history of suicide attempts and those without such a history. Factor analysis revealed three factors of increasing self-destructiveness: low self-esteem or inwardness; extreme self-hate; and actual impulses toward destruction of the self. Empirical evidence indicates that the latter category, "destruction of the self," may contain primary factors distinguishing actual suicide attempters from those individuals who represent a lesser threat to themselves. Assessing the level and intensity of destructive "voices" may correlate with suicide potential. (Contains 42 references.) (CC)

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VOICES IN SUICIDE

The Relationship Between the Firestone Voice Scale for Self-Destructive Behavior and Self-Destructive Life-Styles

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ABSTRACT

This article presents findings from recent research (L. Firestone, 1991) demonstrating a significant relationship between parental introjects or "voices" and self-destructive behavior. The "voice" is defined as a systematized, integrated pattern of negative thoughts, accompanied by angry affect, that is the basis of an individual's maladaptive behavior. The study applied the author's theoretical construct of the voice to the development of the Firestone Voice Scale for Self-Destructive Behavior. Results of administering the scale to 507 subjects in psychotherapy showed that the instrument distinguished between those individuals with a past history of suicide attempts and those without such a history.

Factor analysis revealed three factors of increasing self-destructiveness: F1 (low self-esteem or inwardness); F2 (extreme self-hate); and F3 (destruction of the self). Empirical evidence showed that the category "destruction of the self" may contain primary factors distinguishing suicide attempters from those individuals who represent a lesser threat to self.

INTRODUCTION

Psychopathology or "mental illness" can be more accurately conceptualized as a limitation in living, imposed on the individual by inadequate, immature, or hostile parenting, internalized in the form of negative thought processes ("voices"), and later manifested in self-limiting and/or self-destructive life-styles. In this sense, varieties of so-called mental illness are subclasses of suicide rather than the reverse.

All aspects of giving up of self, one's sense of reality, goal-directed activity, and appropriate emotional response represent a defensive, self-destructive orientation toward life that inevitably leads to neurotic or psychotic symptom formation. The extent of emotional deprivation and destructive parenting will determine the degree of psychological maladjustment. Inimical thought patterns and emotional attitudes are introjected or incorporated into the self system that strongly influence or control the relinquishing of one's unique identity and the narrowing of life experiences. Suicide represents the ultimate abrogation of self and the extreme end of the continuum of self-destructiveness. Therefore, it is productive to study this phenomenon as it sheds light on the entire spectrum of "mental illness."

Clearly, suicide, depression, and self-destructive actions are multidetermined and biological components should be considered in determining their etiology, particularly in Bipolar Disorders. In our studies, however, we focus primarily on the psychodynamics of suicide and emotional disorders.

The paper presents findings from a recently completed research project that demonstrate the strong connection between parental introjects or "voices" and self-destructive behavior. The "voice" is defined here as a systematized, integrated pattern of negative thoughts and attitudes, antithetical to the self and hostile toward others, that is the basis of an individual's maladaptive behavior. It is important to point out that the voice concept is not restricted to cognitive processes, but is generally associated with varying degrees of angry affect.

Self-attacks, "voices," vary along a continuum of intensity from mild self-reproach to strong self-accusations and suicidal ideation. Similarly, self-

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destructive behavior exists on a continuum ranging from self-denial; self-criticism; self-defeating behaviors, i.e., behavior contrary to one's goals, accident-proneness, substance abuse; and eventually to direct actions that cause bodily harm. Clinical evidence supporting the relationship between internal voices and self-destructive living suggested research possibilities that would lead to an accurate prediction of an individual's suicide potential.

Data obtained during preliminary studies (R. Firestone, 1988) utilizing Voice Therapy procedures led to the following hypotheses. The source of negative thought processes and their development within the personality is related to (a) the projection of negative parental traits onto the child; (b) the child's imitation of one or both parents' maladaptive defenses; and (c) the internalization and incorporation of parental attitudes of covert aggression toward the child. As the degree of trauma experienced in childhood increases, the level of intensity of voice attacks parallels this progression, and there are increasingly angry, vicious attacks on the self. These voices are manifested in an individual's retreat into inwardness, feelings of extreme self-hate, and eventually impulses toward self-destructive action (R. Firestone, 1988).[1]

In summary, the effects of negative early environmental influences are retained in the form of destructive voices within the adult personality. Thus, the voice plays a major role in precipitating and maintaining a wide range of maladaptive behaviors that are mistakenly classified or defined as a disease entity or "mental illness."

REVIEW OF THE LITERATURE

Some Contemporary Views of Mental Illness

The categorization of emotional disturbance as a medical abnormality or illness has been challenged by a number of theorists and clinicians (Szasz, 1961, 1963, 1978; Laing & Esterson, 1964/1970). Szasz (1963) suggests that "mental illnesses...be regarded as the expressions of man's struggle with the problem of *how* he should live" (p. 16).

In attacking the "myth of mental illness," Szasz faults the careless use of language for perpetuating beliefs about psychological distress that are as archaic as the belief in witchcraft. Szasz (1990) argues that the goal of "treatment" is "to increase the patient's knowledge of himself, others, and the world about him and hence his freedom of choice and responsibility in the conduct of his life" (p. 172). He is opposed to the progressive medicalization of psychotherapy which he sees as deriving from an increasing adoption of medical formulations about "symptoms" that are, in reality, manifestations of disturbed ways of living.

Laing and Esterson (1964/1970) share Szasz's abhorrence of diagnostic labels and medical models as applied to emotional disturbances. In *Sanity, Madness and The Family*, Laing and Esterson argue that the term "schizophrenia" was a clinical attribution "made by certain persons about the experience and behaviour of certain others" (p. 19). They reserve final judgment about the validity of such attributions, concluding that:

> It is most important to recognize that the diagnosed patient is not suffering from a disease whose aetiology is unknown, unless he can prove otherwise. He is someone who has queer experiences and/or is acting in a queer way, from the point of view usually of his relatives and of ourselves. (p. 18)

Feinstein and Krippner (1988) view psychological maladies as originating in the dysfunctional personal myths of the patient. A number of major philosophically-oriented approaches, including those of Frankl, May, Bugental, Rogers, Perls, and Maslow, are based on the assumption that an imbalanced emotional life is the result of a person's "cultural beliefs, his philosophy and ethical values, and his spiritual development" (Zeig & Munion, 1990, p. 159).

Suicidologist Edwin Shneidman (1989) has emphasized that suicide is *not* an illness, rather it is:

> a human, psychological orientation toward life, not a biological, medical disease.... Suicide is a human malaise tied to what is "on the mind" including one's view of the value of life at that moment. It is essentially hopeless unhappiness and psychological hurt—and that is not a medical condition. (p. 9)

In this context, Menninger's view (1938) of psychosis deserves special attention: he conceived of schizophrenia as a method of self-destruction:

> This departure from reality standards enables the psychotic person to destroy himself in a unique way not available to anyone else. He can *imagine* himself dead; or, he can imagine a part of himself to be dead or destroyed. This fantasied self-destruction, partial or complete, corresponds in its motives to actual self-mutilation and suicide. (p. 187)

In their writing, suicidologists Kalle Achte (1980) and Norman Farberow (1980) describe indirect suicidal manifestations in non-medical terms, that is, as the methods people use to sabotage their own success, seemingly preferring to live miserable, restricted lives (R. Firestone, 1990b). Space does not permit more than a brief mention of the author's depiction of "mental illness" as manifestations of microsuicidal and suicidal behavior (R. Firestone, 1986, 1988, 1990a; Firestone & Seiden 1987, 1990). Our expanding knowledge of negative cognitive processes and related affect has been applied to sexual dysfunctions, personal limitation, conflict in marital relationships, faulty parenting practices, and more serious child abuse (R. Firestone 1985, 1989, 1990d). Clinical and empirical studies tend to confirm our view that "mental illness" represents a narrowing of one's life-space, a constriction of experience, and a controlled destruction of the personality.

The "Voice"—Psychoanalytic and Cognitive-Behavioral Approaches

Many theorists, beginning with Freud, have identified aspects of a negative thought process and split ego functions. In *Group Psychology and the Analysis of the Ego*, Freud (1921/1955) described cases of melancholia in which there is "a cruel self-depreciation of the ego combined with relentless self-criticism and bitter self-reproaches..." He went on to state, "but these melancholias also show us something else... They show us the ego divided, fallen apart into two pieces, one of which rages against the second" (p. 109).

In Guntrip's (1969) analysis of Fairbairn's theory of ego-psychology, he uses the terms *libidinal ego* and *antilibidinal ego* to delineate parts of the split ego. Guntrip links the punishing ego-function of the antilibidinal ego to depression and suicide:

> The degree of self-hate and self persecution going on in the unconscious determines the degree of the illness, and in severe cases the person can become hopeless, panic-stricken, and be driven to suicide as a way out. (p. 190)

Beck (1976), Ellis and Harper (1961/1975), and Kaufman and Raphael (1984) present similar concepts in their discussion of maladaptive thought processes. It is apparent that the phenomena described by these clinicians are similar to the self-attacks identified by our subjects through the laboratory procedures of Voice Therapy. The concept of the voice and methods of Voice Therapy are more deeply rooted in the psychoanalytic approach than in a cognitive-behavioral model. Our theoretical focus is on understanding the psychodynamics of the patient's functional disturbance in the present, and our methods are based on an underlying theory of personality that emphasizes a primary defensive process (R. Firestone, 1988, 1990c).

BACKGROUND OF THE STUDY

The Development of the Firestone Voice Scale for Self-Destructive Behavior (FVSSDB)

My primary purpose in initiating an empirical research project was to predict an individual's suicide potential because accurate prediction could potentially save lives. Secondarily, I was interested in determining whether the continuum of voice attacks would actually parallel manifestations of self-destructive behavior as had been hypothesized. Would the results of the proposed research be consistent with our theoretical orientation and support our initial findings? If so, they would be of significant value because many theorists have proposed the idea of the continuous nature of self-destructive behavior and restrictive life-styles, yet this concept has not been subject to empirical research. In addition, the research could shed light on the relationship between powerful psychological defenses formed in childhood and later personality malfunctions.

Subsequently, Lisa Firestone elected to conduct the research project to fulfill requirements for a doctoral dissertation in clinical psychology. Her study (L. Firestone, 1991) involved the application of voice theory to the development of a scale to

assess self-destructive behavior (later termed the Firestone Voice Scale for Self-Destructive Behavior). Her goal was to establish the validity and reliability of the scale. It was hypothesized that the scale would reveal valuable information about the content of an individual's negative thought processes. By identifying where and with what frequency the individual's thoughts lie along the Continuum of Negative Thought Patterns (Figure 1), it was expected that one could better assess the seriousness or "dangerousness" of suicide intent.

Description of the Scale

The "rational" approach (Jackson, 1970) to scale construction was adopted from the onset in the development of the FVSSDB. The items for the FVSSDB were originally chosen on the basis of the author's (1986, 1988; Firestone & Seiden, 1987) theory of the dynamics underlying suicide. Items were drawn from actual clinical material obtained during the author's 18-year longitudinal study of the "voice." Items on the scale were made up of self-critical statements or "voices" gathered from patients and subjects over the course of this clinical investigation. It was noted that more extreme "voice" attacks were manifested by individuals who had made past suicide attempts.

Based on a pretest administered to individuals who had made previous suicide attempts and to nonattempters, the scale was shortened and revised. Items found to significantly discriminate between the two groups, attempters and nonattempters, were retained. The revised scale consists of 110 items, equally drawn from 11 levels of self-destructiveness proposed by the author on the Continuum of Negative Thought Patterns.

Methods

In the main study, the revised questionnaire was administered to 507 subjects currently in psychotherapy. The subjects' ages ranged from 16 to 73, with an average age of 38. Of the participants, 169 were male (33%) and 338 were female (67%). The subjects were predominantly white (89%), even though a concerted effort was made to include minority subjects. Respondents were tested at sites throughout the United States and western Canada. They were asked to endorse how frequently they experience negative thoughts or "voices" on a 5-point Likert-type scale (see Figure 2). In addition, the subjects were asked to complete a battery of nine other instruments covering diverse areas of self-destructiveness in order to provide construct validation for the various levels of self-destructiveness proposed by R. Firestone (L. Firestone, 1991). The tests included the Beck Hopelessness Scale (Beck & Steer, 1988), the Suicide Probability Scale (Cull & Gill, 1988), and the Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983), among others. Client participants were administered the battery of tests in a private setting with the main researcher or a research assistant, who was present to answer questions or communicate with those who might become disturbed by feelings aroused during the testing. Following testing, the Beck Hopelessness Scale and the Suicide Probability Scale were scored within 24 hours, and the therapist was informed if any of the scores were in a range of concern.

It was hypothesized that the scale would be able to distinguish between those individuals with a past history of suicide attempts and those without such a history. Both therapists and subjects provided information on the criterion variable (subjects' past suicide attempts). It was found that the sample chosen included 93 persons who had made suicide attempts and 414 who had not. We anticipated that the scale would enhance our ability to predict suicide potential as well as identify a wide range of self-destructive behavior patterns.

In addition, the scale, combined with our theoretical orientation, would provide clinicians with a comprehensive framework for understanding the dynamics of alienation, self-attack, and suicide. The majority of scales previously developed to assess suicide potential focus on data already known to be correlated with suicide. In contrast, the FVSSDB is based on accessing and measuring a partially *unconscious* process hypothesized to underlie suicidal behavior.[2]

It was expected that items on the scale would elicit partially unconscious material in respondents, thereby lending the instrument more discriminatory power than scales based on descriptive information concerning behaviors known to be correlated with suicide.

Figure 1

CONTINUUM OF NEGATIVE THOUGHT PATTERNS

Levels of Increasing Suicidal Intention	Content of Voice Statements
Low Self-esteem	
1. Self-critical thoughts of everyday life, self-depreciation.	*You're incompetent, stupid. You're not very attractive. You're going to make a fool of yourself.*
2. Voices rationalizing self-denial. Thoughts praising and approving selflessness and asceticism.	*You're too young and inexperienced to apply for this job. You're too shy to make any new friends, or Why go on this trip? It'll be such a hassle. You'll save money by staying home.*
3. Cynical attitudes toward others combined with self-attacks leading to alienation and distancing.	*Why go out with her (him)? She's cold, unreliable; she'll reject you. She wouldn't go out with you anyway. You can't trust men (women).*
A Tendency Toward Isolation	
4. Thoughts influencing isolation. Rationalizations for time alone, but using time to attack oneself.	*Just be by yourself. You're miserable company anyway; who'd want to be with you? Just stay in the background, out of view.*
Psychological Pain	
5. Vicious self-abusive thoughts and self-accusations (accompanied by intense angry affect).	*You idiot! You bitch! You creep! You stupid shit! You don't deserve anything; you're worthless.*
Substance Abuse	
6. Thoughts urging excessive use of substances followed by self-accusations (weakens inhibitions against selfdestructive actions, while increasing guilt and self-recrimination).	*It's okay to do drugs, you'll be more relaxed. Go ahead and have a drink, you deserve it. (later) You weak-willed jerk! You're nothing but a drugged-out drunken freak.*
Sense of Hopelessness	
7. Thoughts urging withdrawal or removal of oneself completely from the lives of people closest. (Rational, moral justification of immoral acts, e.g., one's children would be better off if one left or committed suicide.)	*See how bad you make your family (friends) feel. They'd be better off without you. It's the only decent thing to do — just stay away and stop bothering them.*
Progressive Withdrawal from Favored Activities	
8. Voices influencing person to give up priorities and favored activities.	*What's the use? Your work doesn't matter any more. Why bother even trying? Nothing matters anyway.*
Perturbation (Intense Agitation)	
9. Injunctions to inflict injury on self at an action level (intense rage against self). (Basis of self-mutilation sometimes observed in seriously disturbed patients.)	*Why don't you just drive across the center divider? Just shove your hand under that power saw!*
10. Thoughts planning details of suicide (calm, rational, often obsessive, indicating complete loss of feeling for self).	*You have to get hold of some pills, then go to a hotel, etc.*
11. Injunctions to carry out suicide plans (extreme thought constriction).	*You've thought about this long enough. Just get it over with. It's the only way out!*

Any combination of the voice attacks listed above can lead to serious suicidal intent. Thoughts leading to isolation, ideation about removing oneself from people's lives, beliefs that one is a bad influence or has a destructive effect on others, voices urging one to give up special activities, vicious self-abusive thoughts accompanied by strong anger, voices urging self-injury and a suicide attempt are all indications of high suicide potential or risk.

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Figure 2

FVSSDB

All people experience "voices" or thoughts that are critical and destructive toward oneself and others. For example, when about to give a speech or public talk, a person might think to him/herself:

"You're going to make a fool of yourself."

When a man or woman is about to call someone for a date, he or she might hear or think:

"Why would he (she) want to go out with you?"

Negative thoughts are a part of everyone's thinking process. Please indicate the frequency with which you experience the following "voice."

	1 NEVER	2 RARELY	3 ONCE IN A WHILE	4 FREQUENTLY	5 MOST ALL OF THE TIME
For example, you think or say to yourself: "You're so stupid!"					
1. "Just stay in the background."					
2. "People are no damn good."					
3. "Look at all this pain you have to go through. If you just weren't here, you wouldn't have to go through this pain."					
4. "Why buy a new car? It'll just get scratched or stolen anyway."					
5. "You just have to try harder."					
6. "You have to find a place no one will find you."					
7. "Go ahead and have a drink, you deserve it."					

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Results

The results of Lisa Firestone's empirical investigation provided support for the reliability and validity of the Firestone Voice Scale for Self-Destructive Behavior. Through evaluating the structure of the FVSSDB [by estimating Cronbach's (1951) alpha coefficient], it was determined that the internal consistency of the total scale was very high (alpha = 0.98) as well as for the subscale alpha, ranging from 0.78 for Level 2 (self-denial) to 0.97 for Level 11 (injunctions to commit suicide) (see Hays & Hayashi, 1990). The FVSSDB total score correlated significantly with the Suicide Probability Scale, r = 0.77 (p .05). The FVSSDB total also correlated significantly with therapists' overall evaluation of the self-destructiveness of the clients, r = 0.40 (p .05). A Guttman Scalogram Analysis confirmed the hypotheses regarding the interrelatedness and continuous nature of self-limitation and self-destructiveness (see Figure 3).

Perhaps the most promising results were obtained in establishing the criterion-related validity of the scale. It was demonstrated that scores on the scale correlated significantly higher than the Beck Hopelessness Scale or the Suicide Probability Scale with subjects' prior suicide attempts for this particular sample. For example, the Beck Hopelessness Scale showed only 13 of the 93 suicide attempters scoring in the range of severe concern. In contrast, the FVSSDB was found to have 41 individuals of the 93 attempters scoring in the highest ranges of concern, while only 17 individuals scored in either the no or mild range of concern. The FVSSDB's correlation with subject's previous suicide attempts was r = 0.31 (p .<05), compared with the SPS, r = 0.26, and the BHS, r = 0.18. Logistic regression analysis showed that the FVSSDB could add significantly to our ability to determine suicide potential. The difference between logic coefficients when the FVSSDB, BHS, and SPS were compared was $X(1, N = 383) = 7.268$, $p < .05$. A short form, the Firestone Voice Scale for Suicide, was also found to have a significantly higher correlation with prior suicide attempts than other instruments in the battery of tests.

One interesting finding was that subjects reported that it was easy to identify with negative thoughts stated in the second person format on the scale. On a number of occasions, clients answering the questionnaire made comments such as "I see that my pattern is to be inward and isolated" or "I didn't realize I was talking to myself so much." These comments and others strengthened our informal hypothesis that items on the scale were closely related to internalized thought patterns that were only partially conscious. Indeed, answering questions in this format gave respondents a feeling of being understood. Moreover, therapists reported that their clients brought up topics not previously mentioned in their sessions and expressed their emotions more openly and freely in the weeks following testing.

LEVELS OF INTENSITY OF THE VOICE

Clinical Studies

In laboratory procedures (Voice Therapy) in which subjects verbalized their self-critical thoughts, we were able to identify three levels of the voice in terms of intensity and content: (1) at the first level, we discovered that every individual was able to identify a self-critical thought process or internal dialogue; (2) when subjects verbalized their self-attacks in a dramatic or cathartic manner, they often launched into an angry diatribe against themselves that was shocking in its intensity; (3) on a deeper level, we observed intense rage toward the self, expressed as suicidal impulses or commands to injure oneself (R. Firestone, 1986).

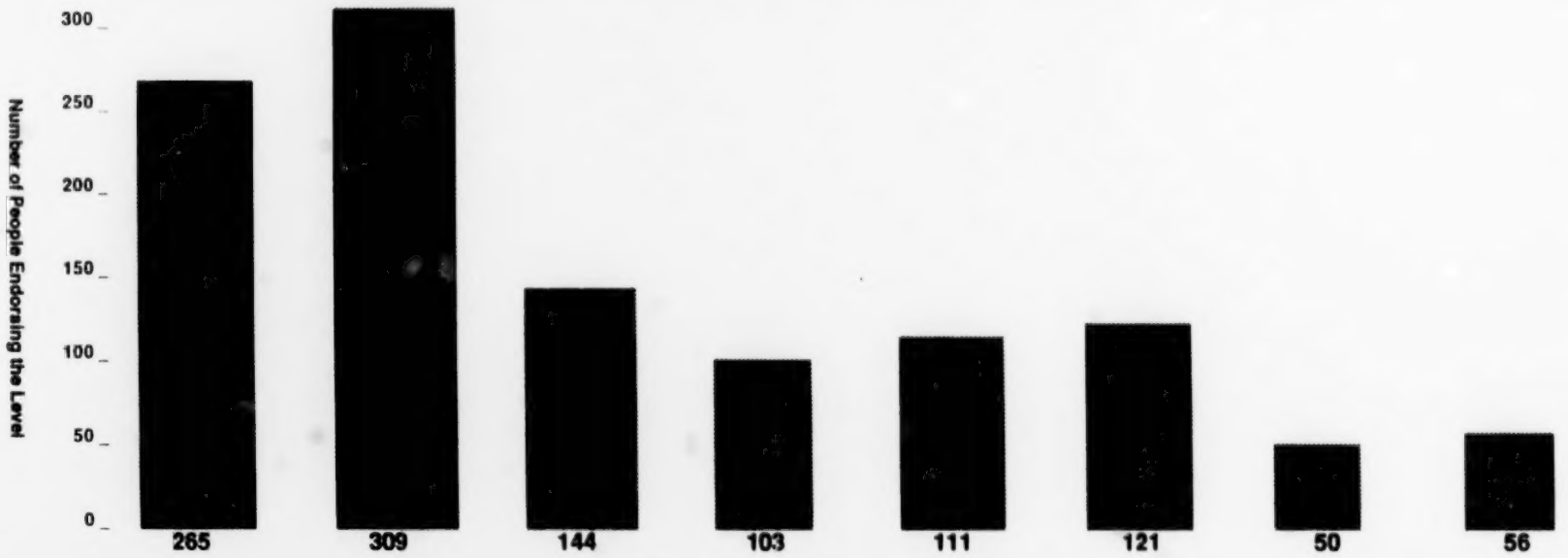
The levels of intensity correspond to different aspects or functions of the voice that progressively influence maladaptive behaviors along the continuum of self-destructiveness. There are two essential modes of operation. The first refers to thought processes that lead to self-denial, attitudes that are restrictive or limiting of life experience, while the latter, self-attack, refers to self-destructive propensities and actions. Some overlap clearly exists between these two aspects of the voice; however, the prohibitive quality appears to be based on the child's imitation of, and adaptation to, the parental defense system, while the malicious aspect of the thought process is more closely related to repressed or overt parental aggression.

The restrictive quality of the voice functions to limit one's experience and stifle one's enthusiasm, spontaneity, spirit, and sense of adventure. These self-attacks restrain or completely block an individual's wants and desires before they can be

Figure 3

GUTTMAN SCALOGRAM ANALYSIS FOR THE FVSSDB

Everyday Voices	Isolation	Psychological Pain	Addictions	Hopelessness	Giving Up on Oneself	Thoughts Planning Suicide	Injunctions to Commit Suicide
Voices Engendering Low Self-Esteem Through Self-Criticism, Self-Denial and Cynicism	Voices Encouraging Isolation, Time Alone to Attack Oneself	Vicious Self-Abusive Voices and Accusations	Voices Influencing Addictions Combined with Criticism of Self for Engaging in Addiction	Voices Rationalizing Removing Oneself from the Lives of People Closest	Voices Influencing Progressive Withdrawal from Favored Activities	Obsessive, Calm, Rational Thoughts Indicating Complete Loss of Feeling for Self	Extreme Thought Constriction, with Injunctions to Take Action on the Suicide Plan



- N=507
- 2.5 Line of Endorsement (on average, a response between "rarely" and "once in awhile" on each item in a level)
- Coefficient of Reproducibility = 0.905
- Coefficient of Scalability = 0.625

translated into action. Negative thoughts provide seemingly rational reasons for self-denial, isolation, and alienation from other people.

The malicious aspect of the inimical thought process issues directives to mutilate the self emotionally and/or physically (R. Firestone, 1988). These thought patterns are accompanied by intense anger and even rage against the self. When verbalized out loud, in the second person, voices, composed of vicious, degrading self-accusations and injunctions to injure oneself, are very powerful and dramatic. It is important to emphasize that, in almost every case, emotional catharsis appeared to decrease the need for action. Facing up to the enemy within acted to relieve the pressure, and individuals gained a measure of control over self-destructive impulses.

Empirical Findings Related to the Continuum of Intensity of Voice Attacks

The results of a confirmatory factor analysis (see Figure 4) of the assessment scale revealed three factors of increasing self-destructiveness that appear to correspond to increasing levels of angry affect accompanying voice attacks (L. Firestone, 1991). When the factor analysis was completed, Factor 1 was initially named "Low Self-Esteem." It includes the first four levels of the Continuum of Negative Thought Patterns: everyday self-criticism, self-denial, cynicism, and isolation. I contend that Factor 1 should more accurately be termed inwardness.[3] It includes self-critical thoughts (Level 1); self-denial (Level 2); cynical or hostile attitudes toward others (Level 3); and gradual withdrawal into isolation (Level 4). Subjects in our pilot studies identified this aspect of the voice as influencing them to be self-critical, to deny themselves pleasurable experiences, to think cynically about others, to avoid becoming invested in relationships, and to spend more time alone and isolated from others. Negative thoughts from the first four levels on the Continuum Chart were endorsed with a high frequency by subjects, indicating the universality of these particular patterns. Indeed, there is a split in every individual psyche; each person is subject to self-destructive voices and manifests varying degrees of inwardness and self-hatred.

Factor 2, Extreme Self-Hate, includes vicious, self-abusive thoughts, obsessive ruminations, often accompanied by intense rage against the self (Level 5); and thoughts engendering hopelessness and urging the withdrawal or removal of oneself from significant others (Level 7). Voice statements from both these levels represent a strong self-hating point of view. Factor 2 may include areas of overlap between voices that mediate self-restrictive lifestyles and those underlying more serious destruction of self. This level of intense self-hatred appears to be an important step in the progression toward overt self-destructive acts because it leads to considerable perturbation and psychological pain.

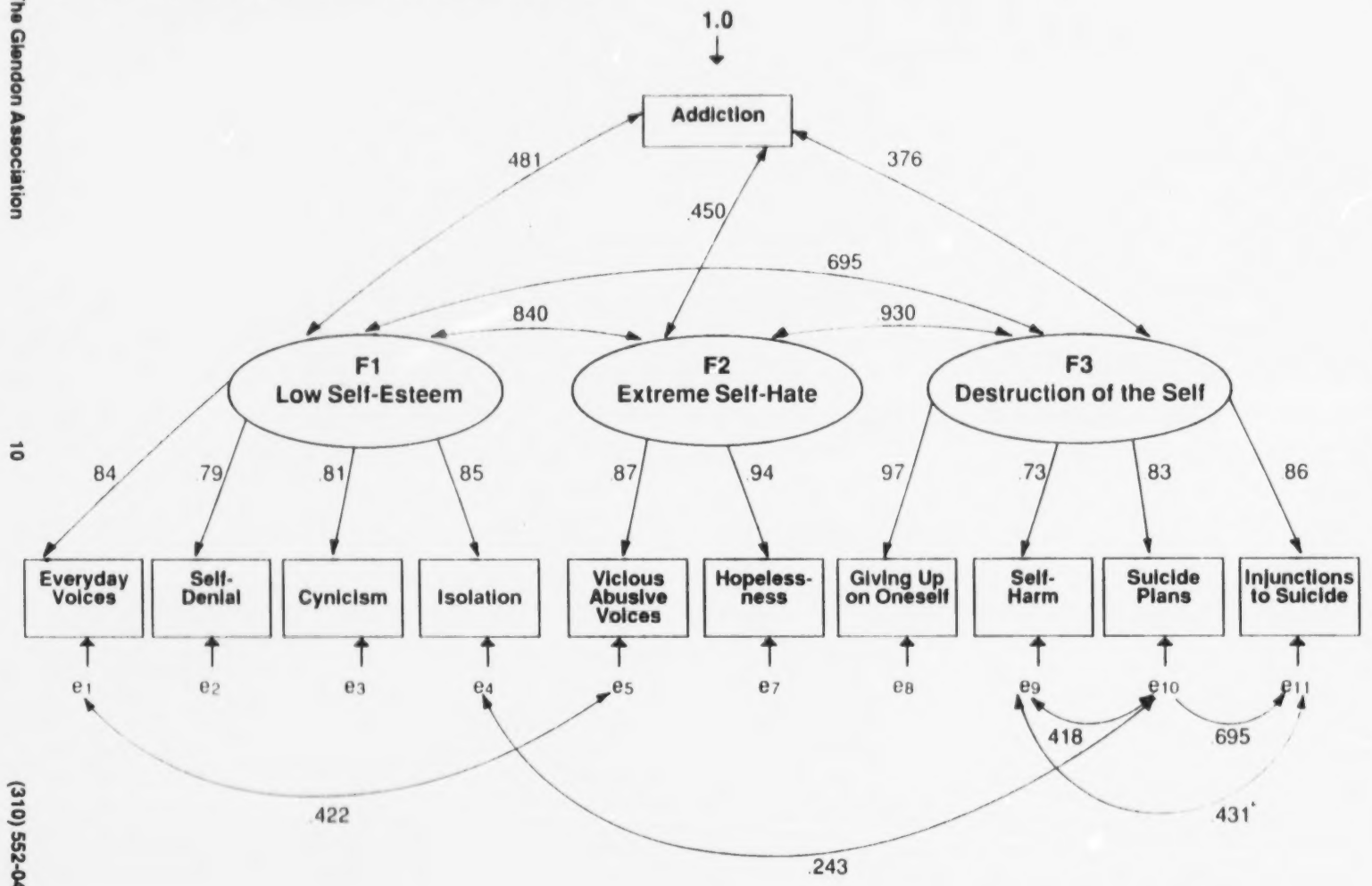
Factor 3, Destruction of the Self, includes Levels 8 through 11 on the Continuum Chart, thoughts associated with giving up one's priorities and favored activities or points of identity, injunctions to harm oneself, thoughts planning suicide, and injunctions to commit suicide. This cluster includes acting out the destructive level, both psychologically and physically. For example, Level 8 includes thoughts influencing the individual to give up points of identity and his/her investment in life by indicating that "nothing matters." This type of thought process (the divestment of energy or de-cathexis) leads to alienation from the self and extinction of the personality (psychological suicide). Level 11 includes actual commands to commit suicide or murder oneself and directly predisposes action.

Case Report

An example of these three factors is illustrated in an interview with a woman who made a serious suicide attempt and who barely survived through a last minute call for help (R. Firestone, 1986).[4] At the time of her attempt, she was unaware that a destructive thought process was gradually gaining ascendence over her rational thinking and assuming control of her actions. Later, utilizing the procedures of Voice Therapy, she was able to clearly recall the thoughts she experienced during that period of her life.

In the transcript that follows, one can observe the progression of thoughts and the increasing intensity of her murderous rage toward self. The interview begins with Susan describing thoughts associated with feelings of low self-esteem, cynical thoughts toward others, and those urging her to isolate herself.

Figure 4. Confirmatory Factor Analysis of the FVSSDB



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Factor 1—Inwardness and Isolation

I was depressed. I felt down. I had thoughts like "You don't matter to him," and "You don't really like him. You don't like him. He doesn't matter that much to you, either."

I was conscious of trying to look okay to my friends, to the people who I was around.

I told myself: "Don't let anybody see what's going on. Look okay. Smile if he walks by. Smile. Answer him. Look normal. Don't let anybody know what's going on."

I tried to get alone, because this process occurred when I was alone. I couldn't carry it off if there were other people around. The voice said "Get alone. You need some time for yourself. Get alone just so you can think."

And once I would get alone, either driving around somewhere or just walking around by myself, then these other voices, the more destructive ones, would start.

Factor 2—Extreme Self-Hate

At this point, Susan's anger toward herself became progressively more intense. As destructive thoughts increasingly dominated her point of view, her self-attacks became more vicious:

I felt like I was bad, like there was something really bad about me that I couldn't fix. I hated myself. I couldn't stand myself. I don't know why.

I thought, "You're so ugly. Of course you can't stand to look at yourself. Who would choose you? You thought you mattered to him, but you don't any more. You don't matter to anyone! You worm! You don't matter!"

*Who would care if you were gone? No one! They might miss you at first, but no one would **really** care!"*

Factor 3—Destruction of the Self

During the hours immediately preceding the ingestion of a lethal dosage of barbiturates and Valium, Susan finalized the details of her plan to kill herself. The decision to end her life to some extent relieved the perturbation and psychological pain she had been experiencing during the previous weeks, feelings she expresses in the following sequence:

I thought things like "If you don't matter, what does matter? Nothing matters! What are you waking up for? You know you hate waking up in the morning, why bother? It's so agonizing to wake up in the morning, why bother doing it? End it. Just end it!"

I would think endlessly about the details:

"When are you going to do it? Where are you going to do it? How are you going to do it. Come on, when are you going to do it?You've got to find a good time when nobody is going to miss you, when you can get away."

At times the voice would sound rational like:

"Look, this is really something you should do. You've thought about it long enough. You decided you're going to do it. Now do it! Quit fooling around and just get it over with."

I know that I took enough pills to kill myself. I remember thinking: "Okay, now do it! Coward! Now do it already. You've got these pills—go ahead, start taking them. Now do it and do it right!"

DISCUSSION

The individuals who participated in our clinical studies traced the source of their negative or hostile thoughts toward themselves to early family interactions. They identified their self-attacks as statements they had either heard stated directly by one or both parents or as attitudes they had picked up in their parents' tone of voice, body language, or other behavioral cues (R. Firestone, 1986). When subjects verbalized their voices dramatically, they actually found themselves utilizing mannerisms, speech patterns, intonations, and accents of their parents.

From these early investigations, we discovered that destructive voices were associated with the core defense the child forms in response to anxiety, pain, and deprivation suffered during the formative years. We concluded that the restrictive, prohibitive aspect of the voice had two major sources: (1) the child's taking on, as his/her identity, negative traits that were disowned by the parents, projected onto the child, and subsequently punished. Through the me-

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chanism of projective identification, children adopt their parents' misconceptions of them and maintain this imposed or "induced" identity in the form of the voice and its behavioral consequences throughout their lives; and (2) the imitation and identification with one's parent or parents' personality traits and psychological defenses. (Most often the child is influenced more by the parent of the same sex.) In this manner, children assimilate their parents' defensive modes of coping with the world.

Self-attack—the malevolent aspect of the voice—appears to be more directly related to parental aggression incorporated by the child under conditions of stress or trauma. When parents become punitive, intensely angry, or explosive, the child attempts to avoid the full experience of anxiety and terror. He/she ceases to identify with the self as a weak, hurting, frightened child and identifies instead with the punishing parent. This shift in identification tends to relieve some of the child's distress; however, he/she internalizes the parents' rage and incorporates their hateful, malicious attitudes in the form of punishing and loathing thoughts and attitudes toward the self. Sandor Ferenczi (1933/1955) and Anna Freud (1966) depicted this important dynamic in their discussion of "identification with the aggressor."

In the interview described above, Susan was able to identify the source of the vicious and degrading voices that first caused her pain, then directed her to escape the pain by killing herself.

This voice was angry toward me: ""You'd better do it. It's the only thing you can do. You'd better do it." Like, "I hate you! I hate you!" (crying)

I just had a thought in relation to my mother. I remember feelings directed toward me from her, when she would get angry at me. I knew she wanted to kill me. That's something I remember. I knew she wanted to kill me. I knew it.

I remember being in a bathroom of my house and my eye level was with the sink. So I must have been 5 or something like that. And I remember her getting furious at me for something which I can't remember, and she started hitting me, which was unusual. I don't remember her hitting me often. But she hit me this one time, and she kept hitting me and hitting me until she noticed that I was bleeding, and then she stopped, when she saw that I was bleeding.

I remember that hatred for some reason—her hatred toward me, being directed toward me. "I hate you!" For what? "I hate you." That was like that voice—my own voice. It turned into my own voice hating myself. That's when it was the most vicious.

In an attempt to relieve her distress and fear, Susan had identified with her powerful, attacking mother. She introjected the hating image of her mother, whom she experienced as wishing her dead. Later, as an adult, she acted out the internalized malevolence in a serious suicide attempt.

Implications

The factor analysis discussed previously provided empirical evidence demonstrating that the category "Destruction of the Self" may well contain the primary factors distinguishing suicide attempters from those individuals who represent a lesser threat to self.[5] In other words, individuals who complete suicide and those who attempt it are compulsively acting out the parental death wishes that were directed toward them. Generally, the most violent actions against the self represent "self-murder" through identification with a covertly hateful or malevolent parent.

The author conjectures that covert or unspoken parental aggression or rage may be more threatening to the child than rage expressed in punitive or explosive actions. The child who is physically abused, although suffering pain, is aware of what is happening, and this has a survival function.[6] On the other hand, the child sensing or perceiving unconscious or covert malevolence in his/her parent or parents experiences intense anticipatory fear or terror in relation to survival. The child's tendency is to split off from the identity of the "victim," identify with the aggressor, and later act out his/her parents' murderous rage in the form of self-mutilation or suicide. Thus, suicidal behavior represents a self-protective defense mechanism. There is a sense of triumph over weakness. The helpless child, facing terrifying circumstances with an uncertain outcome, becomes the powerful, omnipotent parent, thereby achieving an illusion of security and mastery.

CONCLUSION

The research described in this paper tends to confirm the connection between negative thought processes ("voices"), and self-limiting life-styles, self-destructive behavior, and suicide. There are other important implications. As noted previously, subjects in the early clinical studies (R. Firestone, 1988) identified their voices as parental statements or as representative of the overall attitudes they perceived directed toward them from their parents. Subsequently, the items selected for the scale were obtained directly from data gathered during the earlier studies, i.e., from the voice attacks reported by these subjects. The utilization of this clinical material to construct a scale that was later found to discriminate suicide attempters from nonattempters lends support to the hypothesis that destructive voices are associated with self-destructive action and may well represent introjected parental attitudes.

In our opinion, inimical thought processes underlying self-destructive behaviors do *not* originate in an innate aggressive drive or instinct as postulated by Freud (1925/1959) and Klein (1948/1964); rather they are formed in response to a negative or hostile parental environment. We conceive of human aggression as a natural response to frustration and hurt. In the case of suicide, this rage is turned inward against the self.

Every person has suffered some degree of pain in his/her development, has internalized negative voices, and possesses some potential for suicide. Whether or not it is acted out depends on a multitude of factors. However, of utmost importance in predicting suicide is the degree of incorporated parental hostility, particularly parents' covert aggression. The author suggests that parental death wishes are the primary condition for serious suicidal ideation and action. Other clinicians (Rosenbaum & Richman, 1970) have reached similar conclusions, based on data from their clinical studies. Rosenbaum and Richman begin their controversial paper by stating: "We believe that the clinician must ask...'Who wished the patient to die, disappear, or go away?'" (p. 1652).

As noted earlier, there is no single cause of specific symptoms or dysfunctional behavior. All psychological functions are multidetermined. In some cases, somatic aspects clearly outweigh environmental components in the etiology of ego weakness and maladjustment. However, in most cases, it appears that the impact of psychological elements and early family interactions on the child's development exceeds the influence of innate predispositions.

Overall, the results of the empirical study reflect favorably on the concept of the "voice" and the hypothesis that assessing the level and intensity of destructive "voices" would correlate with suicide potential. Further research is suggested, of most importance being a prospective study of five or more years duration, to further evaluate the scale's ability to predict suicide. It would also be of considerable interest to measure the effects or outcome of psychotherapy, testing pre- and post-test responses to the Voice Scales.

In summary, utilizing the concept of the voice and the continuum of self-destructive behaviors to develop our scale led to a significant correlation with other indices of suicide potential and an even more significant correlation with actual suicide attempts than previous scales. The empirical research noted above was based on the rational approach to scale construction, which combined a theoretical framework based on clinical evidence and empirical findings. Our data support the view that emotional or psychological malfunction or disturbance is representative of self-limiting and self-destructive lifestyles that can be more usefully conceptualized along a continuum than defined and categorized as disease entities.

FOOTNOTES

1. Negative voices can be elicited utilizing Voice Therapy techniques that bring thoughts antithetical to the self to the foreground together with associated affect, revealing the totality of one's malevolence toward oneself.

2. Experimental research into unconscious processes is relatively uncommon; however, a long-term project of this nature was reported by Silverman, Lachmann, and Milich (1982), who studied the use of a laboratory method for assessing the impact of unconscious fantasies on behavior. The method used was subliminal psychodynamic activation, wherein schizophrenic patients showed a decrease in pathology after being presented with a

tachistoscopic message reading "MOMMY AND I ARE ONE."

3. The concept of inwardness as described here has a negative or dysfunctional connotation and should not be confused with introversion or introspection.

4. Interview excerpts are taken from published and videotaped material: R. Firestone, 1986; Firestone & Seiden, 1990; Parr, 1985. The author has requested permission from *Psychotherapy* to reprint excerpts from "The 'Inner Voice' and Suicide," Vol. 23, 1986.

5. In the construction of the Firestone Voice Scale for Suicide, designed to screen suicidal patients, the items were selected primarily from items included in this category (Destruction of the Self). These items or voice statements were found to be the most highly correlated with subjects' prior suicide attempts.

6. However, several studies have also demonstrated correlations between physical abuse in childhood and later suicide attempts (Frederick, 1985; Sabbath, 1969).

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